

Little Hoover Commission  
Tuesday, March 27, 9 a.m.  
State Capitol, Sacramento

**Outline of Presentation: Catherine Camp  
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**I. History of Mental Health Funding**

- State-local match; open-ended, then capped
- Large state institutions
- Steady decline in share of state general fund
- Numerous categoricals
- Significant regional differences in funding
- Expansive mandate to serve, significantly underfunded

**II. 1990 Reforms**

- Stable, growing fund source
- Linked to other entitlement, caseload-driven programs with a priority for growth
- Some effort to reduce regional inequities (modest)
- Few categoricals
- State-established target population of most seriously mentally ill

**III. History of Mental Health Governance**

- Extensive, annual state plans
- Categorically organized state experts
- State decisions about state hospitals; local decisions about whether and when to apply for categorical funding for community programs
- Revolving door of state directors in late 1980's
- Bifurcated Medicaid program, fee-for-service and Short-Doyle

**IV. 1990 Reforms**

- Historically-based resource base at local level
- Trust fund controls over resource base
- Planning, managing and delivery decisions made at local level
- Eliminate state plans; substitute annual contract
- Redesigned State Planning Council; redesigned local Mental Health Boards/Commissions
- Consolidate Medicaid program, shift risk from state to counties

**V. Positives from 1990 Reforms**

- Stable funding allowed counties to adapt to new technologies and service patterns. The decade following reform was an intensely creative period, with strong, consumer-driven redesign of programs

- Eligible persons increased 13% in first 10 years; clients served increased 52%
- Services shifted to sickest individuals, generally
- MediCal consolidation permitted the management of limited public mental health funds; and avoided the chaos of the impact of the shift to managed care on public physical health care systems. Generally, mental health resources remained within the public mental health system
- Counties develop formal, risk-sharing mechanisms for the smallest counties, to permit them to jointly buy State Hospital beds and to permit them to assume the risk of consolidated MediCal Mental Health care.

## **VI. Negatives from 1990 Reforms**

- Nothing in the reforms corrected the significant underfunding; they just stopped the erosion. The funding source was even initially inadequate: it took four years to reach the dollar amount of the year before reform.
- While the large Realignment reform kept pace with caseload and COLA, mental health funding has not because growth under the program is targeted to entitlement, caseload-driven programs. For some counties, this is made worse because within mental health a portion of the annual growth is available only to ‘under-equity’ counties.
- The state has not maintained its commitment to provide caseload and COLA adjustments under MediCal. As a result, resources locally have shifted somewhat from indigent seriously mentally ill individuals to Medi-Cal beneficiaries with medically necessary specialty mental health needs (who are not necessarily seriously mentally ill).
- No administrative funds were transferred at the time of reform. All local administrative costs have come at the expense of service funds.
- Despite the auditing and contracting authority of the state, and despite significant data collection costs at both the state and county levels, the system has yet to develop a simple accountability system that policy-makers believe.
- Intensive joint efforts at the state level permitted the constituency to join together and identify a shared reform. That joint effort was not present at the end of the 1990’s, and the constituency was not able to avoid a bitter and unproductive debate over the role of involuntary treatment in the mental health system
- Block grants will always be a problem; policy makers are rarely willing to take political risk for a service system whose planning and management occurs elsewhere. In addition, the most significant fund raising authority exists in California at the state, not local, level. Any long term address of the chronic underfunding of this system will need to take these issues into account.
- Recording agreements, and keeping the integrity of a reform are difficult ten years out, especially in a term-limited world. Some have called for constitutional protections for revenue streams and program limitations.

